6 - 1940

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 8245

FILED MAR 7 1940

Registration District No. 784

Primary Registration District No. 200

Registrar's No. 252

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Lemay Rural Hawkins Road
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: RFD. #8 Lemay, Misouri Hawkins Rd.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community Life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis
(c) City or town Lemay Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Hawkins Rd.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ______ years.

3. (a) PRINT FULL NAME Violet Schroeter

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive ______ years

7. Birth date of deceased December 8 1935
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	4	1	26	hr. ____ min. ____

9. Birthplace Mattese (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Nil

11. Industry or business

FATHER
12. Name August Schroeter
13. Birthplace Mattese (City, town, or county) Mo. (State or foreign country)

MOTHER
14. Maiden name Lydia Westermann
15. Birthplace Oakville (City, town, or county) Mo. (State or foreign country)

16. (a) Informant's own signature Aug Schroeter
(b) Address RFD #8 Lemay, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 7. 40 (Month) (Day) (Year)
(c) Place: burial or cremation St. John Cemetery

18. (a) Signature of funeral director C. Hoffmeister U. & L. Co.
(b) Address 7814 S. Broadway

19. (a) FEB 6 - 1940 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 4 year 1940 hour 9 minute 15 p M.

21. I hereby certify that I attended the deceased from Aug. , 1937, to Feb. 4, 1940 that I last saw her alive on Feb. 4, 1940, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death Spasm from locked bowels — Duration

Due to Endocarditis

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature [illegible] (M.D. or other)
Address 7110 Michigan Av. Date signed 2-5-40

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by .....

....., Registered Apprentice No. .....,

working under my personal supervision.

Signed Edwin H. Leibinger

Licensed Embalmer No. 4049

P. O. Address 6464 Chippewa

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

No. 2B
1-2-21-40
3-1 X22659

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 8245

Registration District No. 784

Primary Registration District No.

Registrar's No. 252

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Violet Schroeter

3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced S
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years | Months | Days | If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 4-40 year hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death Spasm from locked bowel (Gang history
Due to having eaten a large amount of plums & candy
Due to the previous day.
Other conditions Endocarditis
(Include pregnancy within 3 months of death)
not congenital—
Major findings:
Of operations most likely due to infected tonsils JJB
Of autopsy JJB

Duration

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a), Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury

23. Signature Dr Royal J Fobes (M.D. or other)
Address 7110 Mich. Ave. Date signed 2-17-40